Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MIDLANDS MEMORIAL HOSPITAL
3225 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
Liberty Mutual Fire Insurance

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-09-A299-01

MFDR Date Received
July 13, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary July 13, 2009: "We have found in this audit you have not paid what we determine as a 'fair and reasonable' amount for this outpatient surgery."

Amount in Dispute: $4,527.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary August 6, 2009: "The bill was priced at the appropriate fee schedule rate that the providers requesting. The provider has a network PPO agreement with First Health Workers Compensation Services and this bill was priced according to that agreement."

Response Submitted by: Liberty Mutual Fire Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 5 through August 13, 2008	Outpatient Hospital Services	$4,527.86	$4,527.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 21, 2008
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.

- P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES AER PAYABLE
- U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES

Explanation of benefits dated May 7, 2009

- Z547 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANANLYSIS PLEASE CALL (800) 937-6824, THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM.
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES AER PAYABLE
- U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code P303 – "THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT." The respondent's position statement asserts that "The provider has a network PPO agreement with First Health Workers Compensation Services and this bill was priced according to that agreement." Review of the submitted information finds insufficient information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the dates of service in dispute. The respondent did not submit documentation to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed dates of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for

the disputed services is calculated as follows:

- Procedure code C1787, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1767, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1778, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80053, date of service August 5, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $14.77. 125% of this amount is $18.46. The recommended payment is $18.46.
- Procedure code 85002, date of service August 5, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $6.29. 125% of this amount is $7.86. The recommended payment is $7.86.
- Procedure code 85025, date of service August 5, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $10.86. 125% of this amount is $13.57. The recommended payment is $13.57.
- Procedure code 85610, date of service August 5, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.49. 125% of this amount is $6.86. The recommended payment is $6.86.
- Procedure code 85730, date of service August 5, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.38. 125% of this amount is $10.48. The recommended payment is $10.48.
- Procedure code 81003, date of service August 5, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.14. 125% of this amount is $3.93. The recommended payment is $3.93.

- Procedure code 76001, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 63685, date of service August 13, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 222, which, per OPPS Addendum A, has a payment rate of $15,337.45. This amount multiplied by 60% yields an unadjusted labor-related amount of $9,202.47. This amount multiplied by the annual wage index for this facility of 0.9712 yields an adjusted labor-related amount of $8,937.44. The non-labor related portion is 40% of the APC rate or $6,134.98. The sum of the labor and non-labor related amounts is $15,072.42. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $15,072.42 divided by the sum of all S and T APC payments of $23,153.48 gives an APC payment ratio for this line of 0.650979, multiplied by the sum of all S and T line charges of $3,121.65, yields a new charge amount of $2,032.13 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.317. This ratio multiplied by the billed charge of $2,032.13 yields a cost of $644.19. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $15,072.42 divided by the sum of all APC payments is 65.10%. The sum of all packaged costs is $12,900.09. The allocated portion of packaged costs is $8,397.68. This amount added to the service cost yields a total cost of $9,041.87. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $15,072.42. This amount multiplied by 200% yields a MAR of $30,144.84.
- Procedure code 63650, date of service August 13, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 40, which, per OPPS Addendum A, has a payment rate of $4,062.82. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,437.69. This amount multiplied by the annual wage index for this facility of 0.9712 yields an adjusted labor-related amount of $2,367.48. The non-labor related portion is 40% of the APC rate or $1,625.13. The sum of the labor and non-labor related amounts is $3,992.61. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $3,992.61 divided by the sum of all S and T APC payments of $23,153.48 gives an APC payment ratio for this line of 0.172441, multiplied by the sum of all S and T line charges of $3,121.65, yields a new charge amount of $538.30 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.317. This ratio multiplied by the billed charge of $538.30 yields a cost of $170.64. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,992.61 divided by the sum of all APC payments is 17.24%. The sum of all packaged costs is $12,900.09. The allocated portion of packaged costs is $2,224.50. This amount added to the service cost yields a total cost of $2,395.14. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $3,992.61. This amount multiplied by 200% yields a MAR of $7,985.22.
- Procedure code 63650, date of service August 13, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC

payment. These services are classified under APC 40, which, per OPPS Addendum A, has a payment rate of $4,062.82. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,437.69. This amount multiplied by the annual wage index for this facility of 0.9712 yields an adjusted labor-related amount of $2,367.48. The non-labor related portion is 40% of the APC rate or $1,625.13. The sum of the labor and non-labor related amounts is $3,992.61. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $3,992.61 divided by the sum of all S and T APC payments of $23,153.48 gives an APC payment ratio for this line of 0.172441, multiplied by the sum of all S and T line charges of $3,121.65, yields a new charge amount of $538.30 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.317. This ratio multiplied by the billed charge of $538.30 yields a cost of $170.64. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,992.61 divided by the sum of all APC payments is 17.24%. The sum of all packaged costs is $12,900.09. The allocated portion of packaged costs is $2,224.50. This amount added to the service cost yields a total cost of $2,395.14. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $3,992.61. This amount multiplied by 200% yields a MAR of $7,985.22.

- Procedure code 95972, date of service August 13, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 663, which, per OPPS Addendum A, has a payment rate of $97.53. This amount multiplied by 60% yields an unadjusted labor-related amount of $58.52. This amount multiplied by the annual wage index for this facility of 0.9712 yields an adjusted labor-related amount of $56.83. The non-labor related portion is 40% of the APC rate or $39.01. The sum of the labor and non-labor related amounts is $95.84. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $95.84 divided by the sum of all S and T APC payments of $23,153.48 gives an APC payment ratio for this line of 0.004139, multiplied by the sum of all S and T line charges of $3,121.65, yields a new charge amount of $12.92 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this line is $95.84. This amount multiplied by 200% yields a MAR of $191.68.
- Procedure code J0690, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2550, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010, date of service August 13, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $46,368.12. The amount previously paid by the insurance carrier is $33,401.06. The requestor is seeking additional reimbursement in the amount of $4,527.86. This amount is recommended.

Conclusion

The total allowable reimbursement for the services in dispute is $46,368.12. The amount previously paid by the insurance carrier is $33,401.06. The requestor is seeking additional reimbursement in the amount of $4,527.86. This amount is recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $4,527.86 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.